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Right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Puras, submitted in accordance with Human Rights Council resolutions 6/29 and 24/6.

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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Summary

The 2030 Agenda for Sustainable Development and the Sustainable Development Goals provide an opportunity to improve the health and human rights of those furthest behind. Human rights and the right-to-health framework can contribute to their effective implementation and achievement. The present report highlights the mutually reinforcing complementarities between the Goals and the right to health. It considers four issues in focus to illustrate how the right to health can help to address critical implementation gaps within the Sustainable Development Goals framework, namely, equality and non-discrimination; accountability; universal health coverage; and violence.

Contents

		Page
I.	Introduction	3
II.	2030 Agenda for Sustainable Development: key issues and principles	3
III.	The right to health and the Sustainable Development Goals	5
	A. The right to health as a framework for achieving the Sustainable Development Goals	5
	B. Health care and the underlying determinants of the right to health	6
	C. Participation and access to information	7
	D. Obligations under the right to health	8
IV.	Issues in focus	10
	A. Leaving no one behind: equity, equality and non-discrimination	10
	B. Accountability	14
	C. Universal health coverage	18
	D. Violence as a public health issue in the Sustainable Development Goals	21
V.	Conclusions and recommendations	23

I. Introduction

1. The 2030 Agenda for Sustainable Development (General Assembly resolution 70/1) is one of the most important and ambitious global strategies to emerge from the United Nations. The 2030 Agenda includes 17 Sustainable Development Goals, which reflect a holistic approach to transforming the world into a more peaceful, just and inclusive global community. The Goals are focused on social, economic and environmental objectives with attention to good governance, the rule of law, access to justice, personal security and fighting inequality. Sustainable Development Goal 3 focuses on health, with other Goals also including many health-related commitments.

2. Although the process and final outcome are not without important criticism,[1] the negotiation of the 2030 Agenda and the 17 Sustainable Development Goals concluded with a commitment to the promotion and protection of human rights. The 2030 Agenda is grounded in the Universal Declaration of Human Rights and international human rights treaties and is informed by the Declaration on the Right to Development (resolution 70/1, para. 10). Notably, the 2030 Agenda includes a commitment to be "implemented in a manner that is consistent with the rights and obligations of States under international law" (ibid., para. 18). In other words, the realization of international human rights law, which includes the right to health, is in and of itself an explicit objective of the Sustainable Development Goals.

3. At an instrumental level, the Sustainable Development Goals and international human rights law have much to offer each other. With careful attention to human rights, global and national efforts towards the Goals can support the realization of the right to health. Conversely, the right to health and other human rights can play a key role in supporting the Goals. It is that special symbiotic relationship that is the focus of the present report, particularly the contributions that the right to health can make towards the effective implementation of the Goals.

II. 2030 Agenda for Sustainable Development: key issues and principles

4. The 2030 Agenda builds on the United Nations Millennium Declaration, adopted at the start of the new millennium and concluded in 2015. The policy objectives of the Millennium Declaration and the Millennium Development Goals focused on improved human development outcomes in health, education, poverty and gender equality in low-income countries (A/59/422, paras. 8-13). That agenda received unprecedented attention from the international community, funding priorities and international relations throughout its 15 years. The 2030 Agenda inherits that strategic space and will be a powerful policy tool influencing international and domestic development agendas through the second and third decades of the millennium.

[1] Barbara Adams and others, eds., *Spotlight on Sustainable Development 2016: Report of the Reflection Group on the 2030 Agenda for Sustainable Development* (Rheinbreitbach, Germany, Social Watch and others, 2016); Claire E. Brolan, Peter S. Hill and Gorik Ooms, "'Everywhere but not specifically somewhere': a qualitative study on why the right to health is not explicit in the post-2015 negotiations", *BMC International Health and Human Rights*, vol. 15, No. 22 (August 2015).

5. The Millennium Development Goals were narrow in scope, focusing on economic and social issues in low-income nations. Health had particular prominence within the Millennium Development Goals, with three of the eight Goals focused on maternal health, child health and HIV/AIDS, tuberculosis and malaria. The Sustainable Development Goals are broader, covering the economic, social and environmental dimensions of development. They are universal, applying to rich and poor countries, and designed to be integrated, interlinked and cross-cutting. Importantly, the 2030 Agenda makes a broad commitment to "[ensuring] that no one is left behind" and "[reaching] the furthest behind first" with the aim of reducing inequalities within and among countries (Goal 10). This is reflected in a number of Sustainable Development Goals and resonates with the key human rights principles of non-discrimination and equality.

6. Health is central to the Sustainable Development Goals, as it is both an outcome of and a path to achieving poverty reduction and sustainable development. Progress in health is both dependent on and a consequence of progress towards other Goals. Goal 3 is a specific commitment to "ensure healthy lives and promote well-being for all at all ages". Goal 3 is associated with nine targets, which include addressing child and maternal mortality and infectious and non-communicable diseases. The Special Rapporteur welcomes recognition of the emerging burden of non-communicable diseases, which represent the majority of deaths worldwide, with a disproportionate and devastating impact on the poor and marginalized.[2] There are also cross-cutting, systems-oriented targets, including universal access to sexual and reproductive health care and universal health coverage.

7. Almost all of the 17 Goals have a linkage with health, and many are important underlying determinants of health, including:

- Poverty eradication (Goal 1)
- Food security and nutrition (Goal 2)
- Inclusive and equitable quality education (Goal 4)
- Gender equality (Goal 5)
- Sustainable water and sanitation (Goal 6)
- Reducing inequalities within and between countries (Goal 10)
- Making cities and settlements safe (Goal 11)
- Climate change and access to energy (Goal 13)
- Peaceful and inclusive societies, access to justice and inclusive and accountable institutions (Goal 16)
- Global partnerships (Goal 17)

8. The many synergies between the Sustainable Development Goals and the right to health notwithstanding, there are a number of challenges. Many of the health-related targets are reductive in their approach and do not reflect critical right-to-health elements. A superficial interpretation of the health indicators threatens to undermine the fulfilment of right-to-health obligations, for example to ensure that health-care coverage is not merely expanded but that it meets critical right-to-health

[2] World Health Organization (WHO), *Global Status Report on Non-Communicable Diseases 2014* (Geneva, 2014).

requirements, including availability, accessibility, acceptability and quality. Many of the Goals' health-related targets and indicators focus narrowly on biomedical aspects, despite the requirement to ensure that health promotion and primary care are grounded in human rights and modern public health principles. The commitments made in the Declaration of Alma-Ata and the Ottawa Charter for Health Promotion, 1986, should be reaffirmed and revitalized by all stakeholders, and the ninth Global Conference on Health Promotion[3] should serve that purpose.

9. Other important human rights challenges regarding implementation of the 2030 Agenda include the weak accountability requirements, unclear guidance on how to implement the Sustainable Development Goals holistically and a failure to make commitments or offer guidance on how to transform the global financial system to support such a broad and ambitious global strategy. The role of the private sector also poses various human rights challenges.

10. Nonetheless, while the 2030 Agenda may be flawed, it has the potential to improve the lives of many, in particular the most excluded and marginalized. Human rights and the right to health can reinforce many of the Sustainable Development Goals and, where there are implementation gaps, can offer valuable normative guidance towards their meaningful achievement.

III. The right to health and the Sustainable Development Goals

A. The right to health as a framework for achieving the Sustainable Development Goals

11. The present section provides only a very brief introduction to the right-to-health framework and some of the ways in which it can reinforce, strengthen and advance the implementation of the Sustainable Development Goals. It is important to recall a fundamental difference between human rights and the Sustainable Development Goals. While the Sustainable Development Goals are political commitments, the right to health gives rise to legally binding obligations on States to progressively realize the right to health, as well as duties on the part of other actors, and to do so in the context of their policies and programmes on the Goals.

12. Regrettably, the 2030 Agenda does not explicitly state that health is a human right. As mentioned previously, the Sustainable Development Goals are grounded in the Universal Declaration of Human Rights and international human rights treaties. All States have ratified at least one of those treaties. Regional treaties in Africa, Europe and the Americas protect the right to health, as do at least 100 national constitutions worldwide.[4]

13. The right to health is also interconnected with other internationally recognized human rights relevant to the Sustainable Development Goals, including the rights to water, food, adequate housing, education, privacy, freedoms of expression and association, freedom from torture, identity and equality before the law, which must also be respected, protected and fulfilled in the context of the Goals.

[3] See www.who.int/healthpromotion/conferences/9gchp/en.

[4] Hans V. Hogerzeil, Melanie Samson and Jaume Vidal Casanova, "Ruling for access: leading court cases in developing countries on access to essential medicines as part of the fulfilment of the right to health" (Geneva, WHO, 2004).

14. The right to health has been clarified in general comments and observations adopted by the United Nations treaty bodies, including general comment No. 14 of the Committee on Economic, Social and Cultural Rights.[5] An increasingly rich jurisprudence and literature on the right to health has also enhanced understanding of this fundamental right.

15. The paragraphs below elaborate the norms and obligations that are embedded in the right-to-health legal framework and must be factored into and will support progress in meeting the health-related Sustainable Development Goals.

B. Health care and the underlying determinants of the right to health

16. The right to health includes a right to health care. Health care is closely connected to all the targets in Goal 3 and directly reflected in the targets to achieve universal health coverage (target 3.8) and ensure universal access to sexual and reproductive health-care services (target 3.7). The relationship between universal health coverage and the right to health is explored further below, while the right to sexual and reproductive health care has been elaborated in general comments Nos. 14 and 22 of the Committee on Economic, Social and Cultural Rights, as well as in a number of previous reports by the mandate holder (see E/CN.4/2004/49, A/66/254, A/HRC/14/20 and A/HRC/32/32). The right to health can also support and be supported by such targets as the reduction of maternal and newborn and under-5 mortality rates (targets 3.1 and 3.2) and of the incidence of communicable and non-communicable diseases (targets 3.3 and 3.4), the promotion of mental health (target 3.4) and the reduction of the number of deaths from road traffic accidents (target 3.6).

17. The right to health requires that health-care goods, services and facilities be available in adequate numbers; financially and geographically accessible, as well as accessible on the basis of non-discrimination; acceptable, that is, respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements; and of good quality.[6] Several of the Sustainable Development Goal targets are relevant to this framework, including the commitment to increase the training, recruitment and retention of health workers in developing countries (target 3.c), which supports the principle of availability of services.

18. An effective and integrated health system that is based on the human rights principles of equality and non-discrimination, transparency, accountability and participation is at the heart of the right to health. Health systems are all too often not a priority for States or for bilateral and multilateral donors. In addition, they receive scant attention within the 2030 Agenda, yet many of the Sustainable Development Goals and targets are dependent on a strong health system that is adequately funded, transparent and accountable. Without focused investment in health system strengthening, there is little prospect of much progress on the health-related Goals, including addressing the growing burden of non-communicable diseases, universal health coverage and other targets. This implies financial investment, as well as investment in good governance, transparency, participation and accountability mechanisms.

[5] Committee on Economic, Social and Cultural Rights, general comments Nos. 14 and 22; Committee on the Rights of the Child, general comment No. 15.

[6] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 12.

19. The right to health encompasses the underlying determinants of health, including its social and psychosocial determinants. The Sustainable Development Goals address many of these underlying determinants, from specific right-to-health entitlements found in the targets of Goal 3, such as road safety, harmful alcohol and tobacco use and environmental pollution, as well as other Goals and targets, including on clean water and sanitation (Goal 6), education (Goal 4), food (Goal 2), decent work (Goal 8), reducing inequalities (Goal 10), gender equality (Goal 5), poverty reduction (Goal 1), climate change and access to energy (Goal 13), peace, justice and strong institutions (Goal 16) and violence (targets 5.2, 16.1 and 16.2).

20. For example, in addressing climate change and environmental pollution (Goal 13 and target 3.9), States and other actors must recognize the particular health impact that these environmental issues have on certain populations, due in part to socioeconomic inequality, cultural norms and intrinsic psychological factors.[7] Climate change increases the incidence of diseases that already disproportionately affect the poor, such as malaria and diarrhoea. Likewise, environmental pollution contributes to the growing burden of non-communicable diseases, disproportionately experienced by the poor. This increases health expenditures and ill mental and physical health among those who can least afford it, reinforcing the vicious cycle of poverty (A/HRC/32/23, para. 24).

21. Goal 3 will not be met without a robust commitment to addressing all underlying determinants of health or sustained investment in transparent and accountable health-care systems.

C. Participation and access to information

22. The Sustainable Development Goals were born through a uniquely participatory process. They also include important commitments to participation, including target 16.7, Ensure responsive, inclusive, participatory and representative decision-making at all levels, as well as other Goals and targets that are crucial to free, informed and meaningful participation, such as public access to information and the protection of fundamental freedoms (target 16.10).

23. International human rights law recognizes the right of individuals to take part in the conduct of public affairs.[8] Article 12 of the International Covenant on Economic, Social and Cultural Rights requires that States respect the right of individuals and groups to participate in decision-making processes that affect their health and development. Participation should be free, informed, active and meaningful (see A/69/213).

24. States should ensure that rights holders, including those from marginalized groups, are provided with the conditions to participate in the design, implementation and monitoring of laws, policies and strategies relevant to meeting the Sustainable Development Goals. The effective recognition, enjoyment and protection of public freedoms, including freedom of opinion and expression and freedom of peaceful assembly and association, is crucial in this respect.

[7] 2015 *Lancet* Commission on Health and Climate Change, "Health and climate change: policy responses to protect public health", *The Lancet*, vol. 386, No. 10006 (November 2015).

[8] Universal Declaration of Human Rights, art. 21; International Covenant on Civil and Political Rights, art. 25.

25. As a key precondition for the full realization of all human rights, including the right to health, civil society actors working on health-related issues should be able to carry out their work in a safe and enabling environment. The Special Rapporteur is concerned about the limited space for civil society in many countries, including those actors working on health-related rights.

D. Obligations under the right to health

26. As previously stated, the Sustainable Development Goals are political commitments. However, under the international human rights framework, in all their efforts to meet the Goals, States should act in conformity with their obligations to respect, protect and fulfil the right to health. The key elements of States' obligations under the right to health include progressive realization, obligations of immediate effect, maximum available resources and international assistance and cooperation.

27. The right to health is subject to progressive realization, which means that States have an obligation to move expeditiously and as effectively as possible, through deliberate, concrete and targeted steps, towards the full realization of the right (see E/CN.4/2003/53 and Corr.1 and 2). This requires adequate indicators and benchmarks to properly monitor progress over time. Examining how Governments create or miss opportunities to generate income, allocate budgets and actually spend allocated funds is useful to evaluate whether they are meeting their obligations to progressively realize their health and other economic, social and cultural rights obligations to the maximum of available resources (E/2009/90, paras. 44-54 and 74). Tracking how countries are investing resources in different Goals and targets is essential to ensuring that efforts to meet them are channelled properly and that the most marginalized populations get the attention that they deserve.

28. Certain health obligations are of immediate effect and are not subject to progressive realization. This includes core obligations, such as non-discrimination. The Sustainable Development Goals reflect a number of core obligations, such as access to health facilities, goods and services on a non-discriminatory basis, access to food, shelter, housing and sanitation, safe and potable water and essential medicines,[9] and ensuring universal coverage of health-care services.[10] Other core obligations that will be essential to realizing the Goals include the revision of the national and subnational legal and policy environment and the amendment or enactment of laws and policies when necessary; the adoption of a national health strategy that addresses the right to health; and the equitable distribution of health facilities, goods and services.

29. States must also devote maximum available resources to the right to health.[11] In many countries, the health system is underfunded. The commitment in target 3.c to substantially increase health financing is welcome and resonates with this obligation. However, resources accumulated to finance health systems must be expended in the context of good governance, transparency, participation and accountability. Civil

[9] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43.
[10] Committee on the Rights of the Child, general comment No. 15, para. 73.
[11] International Covenant on Economic Social and Cultural Rights, art. 2 (1).

society must be meaningfully involved as a partner in all levels of decision-making and accountability.[12]

30. Maximum available resources include domestic and international resources. Increasing the budget for health may require reallocation of existing resources or generating additional resources. The Sustainable Development Goals require States to enhance capacity for tax and other revenue collection, including through international cooperation. According to the human rights principles of non-discrimination and equality, States should ensure the financing of health on the basis of progressive tax systems with redistributive capacity that benefits poorer householders. Other areas that are critical to ensuring maximum available resources include debt and deficit financing, monetary policy and financial regulation (A/HRC/26/28, para. 25).

31. All States have obligations under international law to take steps jointly and separately through international assistance and cooperation towards the realization of economic, social and cultural rights, including the right to health.[13] Beyond financial and technical assistance, the human rights concept of international assistance and cooperation includes developed States' responsibility to work "actively towards an international order that is conducive to the elimination of poverty and the realization of the right to health" (A/59/422, para. 32).

32. The concept of international assistance and cooperation runs throughout the Sustainable Development Goals and resonates strongly with the principles of global equity, partnership and cooperation that animate the 2030 Agenda, as well as the Addis Ababa Action Agenda of the Third International Conference on Financing for Development. In addition, the human rights concept of international assistance and cooperation provides legal reinforcement to Goal 17 on strengthening the means of implementation to revitalize the Global Partnership for Sustainable Development, including countries' development commitments to fully implement their official development assistance targets (target 17.2), mobilize additional financial resources for developing countries (target 17.3) and assist them in addressing debt (target 17.4).

33. Developed/high-income countries have a duty to provide cooperation and assistance to developing countries to support efforts to realize the right to health in their respective roles as donors and in their roles as members of international and regional development and financial organizations.[14] To comply with those obligations, States have to respect the enjoyment of the right to health in other countries and use their political or legal influence to prevent third parties from violating that right in other countries.

34. Developing countries members of international financial organizations should work to ensure protection of the right to health in those institutions' lending policies, credit agreements and other international measures.[15] They also have an

[12] Society for International Development, Transparency International — Kenya and Kenya Ethical and Legal Issues Network, "Sealing corruption loopholes in Kenya's health procurement systems", Policy Brief, No. 2 (April 2016).

[13] Charter of the United Nations, Articles 55 and 56; Committee on Economic, Social and Cultural Rights, general comments Nos. 2, 3 and 14.

[14] Charter of the United Nations, Articles 55 and 56; Committee on Economic, Social and Cultural Rights, general comment No. 3, para. 14.

[15] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 39.

obligation to use resources at the national level and to seek resources through international cooperation and assistance to realize the right to health.

35. The private sector has a significant bearing in the Sustainable Development Goals as it plays a crucial role — at times positive and at times negative — as a provider of health-care goods and services, as well as in research and development for medicines in many countries. In line with international human rights standards, States have an obligation to protect against interference and harm by the private sector. The adoption and implementation of a robust legal, regulatory and policy framework is critical, and accountability arrangements relating to the private sector, including monitoring, review and remedies, must be in place at the global, regional and national levels.

36. Accountability, equality and non-discrimination are essential components of the right-to-health framework and will be introduced in the following section.

IV. Issues in focus

37. The relationship between the Sustainable Development Goals and the right to health gives rise to many issues of great importance. As space in the present report is limited, the present section provides an introductory exploration of four features of the 2030 Agenda that resonate with the right to health: addressing inequity and equality; accountability; universal health coverage; and violence.

38. The commitments to leaving no one behind and ensuring accountability are fundamental principles of human rights. Universal health coverage is crucial to ensuring equity in implementing the right to health, while violence is a vital and underattended underlying determinant of health and a systemic barrier to gaining access to health care, improving well-being and meeting the Sustainable Development Goals.

39. Each of the aforementioned issues represents a new focus compared with the millennium agenda that requires operational engagement in both rich and poor countries. The challenges reflected by those four issues in focus exist as much among certain segments of the population in developed countries as they do in developing countries. The 2030 Agenda targets and indicators do not adequately address those issues, creating uncertainties about how States are to carry out the business of effective implementation. Human rights and the right to health can offer a legally grounded and instructive framework to address the gaps.[16]

A. Leaving no one behind: equity, equality and non-discrimination

40. Inequality, discrimination and inequity are defining aspects of the global community that shape and influence health policies and outcomes[17] and reflect a

[16] Adams and others, *Spotlight on Sustainable Development* (see footnote 1); International Labour Organization (ILO), *Women at Work Report: Trends 2016* (Geneva, 2016); Office of the United Nations High Commissioner for Human Rights (OHCHR) and Center for Economic and Social Rights, "Who will be accountable? Human rights and the post-2015 development agenda" (New York and Geneva, 2013).

[17] WHO, *State of Inequality: Reproductive, Newborn and Child Health* (Geneva, 2015); A/HRC/29/31, paras. 29-42.

deeply flawed approach to investment in and prioritization of human development. The Millennium Development Goals failed to recognize the importance of equity, non-discrimination and equality in health, which masked inequalities and disparities within and between countries, leaving the poorest and the most marginalized even further behind.[18]

41. The 2030 Agenda commits to prioritizing the poorest and most vulnerable and to reaching the furthest behind first. Ensuring healthy lives for all at all ages (Goal 3) positions equality, non-discrimination and equity as the central health issue in the 2030 Agenda, complemented by Goal 10, which calls for reducing inequalities within and among countries. However, achieving this requires a foundational shift in implementation, one that prioritizes those furthest behind, identifies and gives visibility to those populations, understands the barriers to their exclusion and establishes mechanisms and policies to enable their inclusion and empowerment (E/HLPF/2016/2, para. 109).

42. Regrettably, many of the targets and indicators developed to guide States towards achieving health equality, non-discrimination and equity by 2030 are vague (target 3.4), still commit to tracking progress in the aggregate (indicator 3.8.2) and fail to articulate the interconnected nature of many of the Sustainable Development Goals. This permits Governments to focus on easier targets or narrow implementation plans that can undermine the broader commitment to prioritize those furthest behind first. The right-to-health framework serves as a helpful tool to understand inequities, set priorities and shape a holistic set of implementation mechanisms to address that gap across the 2030 Agenda.

43. The right to health requires States to address holistically a range of barriers arising from inequality and discrimination that impede access to health care and underlying determinants of health and to prioritize vulnerable and poor members of society.[19] This is consistent with the commitment to collectively implement Sustainable Development Goal targets and, importantly, provides normative guidance for prioritization.

Prioritizing resources for health

44. The financial resources required to both develop and gain access to health systems constitute a common barrier to achieving health equity, affecting the health and well-being of the world's poorest and marginalized most acutely. Developing countries, in particular those without strong health systems, face significant challenges to achieving the health-related Sustainable Development Goals. The right to health requires States to prioritize provision for the most poor and marginalized, even in the face of resource barriers, through a range of measures. A few illustrative examples linking various Goals are as follows:

(a) For those living in poverty or without sufficient means, States should ensure health coverage or access to care to prevent discrimination (targets 1.3 and 3.8);[20]

[18] Save the Children, "Leaving no one behind: embedding equity in the post-2015 framework through stepping stone targets" (London, 2015).

[19] Committee on Economic, Social and Cultural Rights, general comment No. 14, paras. 18-19.

[20] Committee on Economic, Social and Cultural Rights, general comment No. 14.

(b) Resource allocation should prioritize equitable distribution and access to health facilities, goods and services and not disproportionately favour health services for privileged populations, such as civil servants or those in large urban areas (target 1.a and Goal 3);

(c) Resource allocation should ensure that the most vulnerable and marginalized have access to an adequate supply of safe and potable water (Goals 3 and 6).

Transforming legal and policy environments

45. Discriminatory laws, policies and practices outside the health space can have a direct impact on the realization of the right to health.[21] For example, poor people are often excluded from access to health services, as well as from underlying determinants of health, such as social housing and other social services, not (only) because they are poor but (also) because they lack security of land tenure or an official legal identity. Criminalized populations may be barred as a matter of law or policy from social housing or other social services. Persons with disabilities may be denied legal capacity and subject to medical interventions or institutionalization without their consent.

46. Equally, such environments exacerbate barriers to health services and result in a range of adverse consequences for poor and marginalized populations. For example, laws criminalizing drug use may drive people who use drugs from life-saving harm reduction services (target 3.3/3.5).[22] Restrictive and punitive drug policies can deprive people suffering from pain of their right to palliative care. Laws criminalizing abortion or restricting the provision of sexual and reproductive information or services put women and girls at increased risk of pregnancy-related complications and maternal mortality (target 3.2/3.7/Goal 5) (see A/HRC/32/32).

47. Repressive laws can also restrict space for civil society actors to operate, thus hindering efforts towards the realization of basic rights and freedoms. Laws prohibiting non-governmental organizations and human rights defenders from working without official registration and limiting or altogether banning access to foreign funding have chilled the efforts to promote the rights of marginalized populations across the globe.

48. In order to overcome inequalities and discrimination relating to health, the right to health requires that States take immediate and comprehensive legal measures, including through the repeal of discriminatory laws, and adopt robust legal protections of equality and non-discrimination (Goal 5 and target 10.3).[23] States should also adopt adequately resourced national health policies that give particular attention to all marginalized groups, and regularly review progress. National health equity strategies that encompass such an approach can help to

[21] Manjima Bhattacharjya and others, "The right(s) evidence: sex work, violence and HIV in Asia — a multi-country qualitative study" (United Nations Population Fund, United Nations Development Programme (UNDP) and Asia Pacific Network of Sex Workers, 2015).

[22] Judith Levine and others, "Risks, rights and health" (New York, UNDP, 2012); Steffanie A. Strathdee and others, "HIV and risk environment for injecting drug users: the past, present and future", *The Lancet*, vol. 376, No. 9737 (July 2010).

[23] Committee on Economic, Social and Cultural Rights, general comment No. 14.

support a holistic and comprehensive approach to tacking inequalities and discrimination.[24]

49. Legal empowerment projects that work with marginalized communities help to secure access to health care. They also respond to and seek to remedy human rights violations, including violations of the right to health. Strengthening legal literacy and legal aid services can also be instrumental in relation to the underlying determinants of health, such as obtaining housing and social welfare benefits (Goal 1 and target 11.1); preventing unlawful or excessive detention and addressing police violence or abuse (Goals 11 and 16); protecting or establishing land rights (Goals 1, 5 and 11); establishing identity and citizenship (target 16.9); preventing gender-based discrimination (Goals 5 and 16); and promoting the meaningful involvement of poor and other marginalized people in decisions affecting their access to health care and underlying determinants of health (targets 5.5 and 16.7).

Participation and empowerment

50. Poor and marginalized populations are often excluded from meaningful participation in decisions about policies that directly affect their health and development. This exacerbates exclusion, discrimination and inequality, and in turn, poor health. Without the participation of communities, particularly the poor and vulnerable, health priorities and systems will continue to favour urban, able-bodied and privileged populations. Regrettably, Goal 3 fails to incorporate participation as an indicator for measuring health progress.

51. Participation of a diverse cross section of civil society, especially user groups, affected communities and grass-roots activists, is essential to ensuring implementation of a global agenda that is inclusive and meaningful for all. The right to health requires that participation be active and meaningful and thus move beyond tokenistic modes of representation. This requires resource mobilization and establishing various mechanisms for civil society to engage with national, regional and international Sustainable Development Goal processes, including the high-level political forum on sustainable development (Goal 17).

52. Community empowerment initiatives working with poor and marginalized communities have achieved extraordinary health outcomes, for example in the global fight to end HIV/AIDS (target 3.3) (E/HLPF/2016/2, para. 107). Economic and social empowerment, such as the decriminalization of sex work and sex worker mobilization, have improved health and identified critical health gaps (Goals 3 and 5).[25] Community mobilization to attain adequate and stable housing for homeless people living with HIV can have life-saving implications for their health (targets 3.3 and 11.1).[26] Efforts to empower parents in vulnerable situations through participatory parental education initiatives reduce the risk of negative health outcomes for their children (Goal 3 and targets 4.2, 5.2 and 16.2).[27] When young

[24] Eric A. Friedman, "National health equity strategies to implement the global promise of SDGs", *Health and Human Rights Journal*, SDG Series blog, 5 October 2016. Available from www.hhrjournal.org/2015/10/sdg-series-national-health-equity-strategies-to-implement-the-global-promise-of-sdgs.

[25] Joint United Nations Programme on HIV/AIDS, "How AIDS changed everything: MDG 6-15 years, 15 lessons of hope from the AIDS response" (Geneva, 2015).

[26] Kate Shannon and others, "Global epidemiology of HIV among female sex workers: influence of structural determinants", *The Lancet*, Vol. 385, No. 9962 (January 2015).

[27] Amy Knowlton and others, "Individual, interpersonal and structural correlates of effective HAART use among urban active injection drug users", *Journal of Acquired Immune Deficiency Syndromes*, vol. 41, No. 4 (April 2006).

girls have access to education, child mortality rates and girls' long-term health improve (Goals 3, 4 and 5) (A/70/213, para. 9). Investments in such initiatives place the human rights principles of autonomy and participation at the centre of public health policy and are critical components of an open, inclusive and peaceful society.

Disaggregated data

53. In conformity with international human rights standards, the Sustainable Development Goals include a commitment to collect high-quality, accessible, timely and reliable data. Realizing the right to health and achieving health equity require identifying and understanding inequalities both within and between countries. Identifying patterns of vulnerability can be accomplished through disaggregated data collection. This is essential to identifying disparities, where targeted efforts are required, monitoring progress and supporting review and accountability. The Inter-Agency and Expert Group on Sustainable Development Goal Indicators has recommended that global Sustainable Development Goal-related data be disaggregated on grounds of "income, gender, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts" (target 17.18). Such disaggregation would be a welcome advance over the Millennium Development Goals, which relied on data presented as national averages.

54. Prioritizing the most vulnerable requires acknowledging that many populations are invisible through traditional data collection methods either because they are excluded from civil registration or because they face other barriers, such as being homeless or criminalized, and never come into contact with official statistical processes. Qualitative data collection methods are a practical and powerful complement to traditional quantitative methods.[28]

55. The 2030 Agenda commitment to strengthening statistics collection in developing countries should include support for disaggregation and high-quality data, in particular regarding civil registration and vital statistics. The Special Rapporteur encourages States to disaggregate data on further grounds and to use both qualitative and quantitative methods. This will be essential to identifying obstacles facing different groups to ensure that suitable legal and policy measures can reduce discrimination and support substantive equality.

B. Accountability

56. Accountability is at the heart of human rights, including the right to health. Accountability for human rights consists of a process that provides rights holders with an opportunity to understand how duty bearers have discharged their obligations, and for duty bearers to explain how they have done so. It has a corrective function, allowing individual or collective grievances to be redressed; it also has a preventive function that helps to determine which laws, policies and programmes are delivering and where adjustments need to be made.[29] This should be viewed as a constructive process that supports individuals and groups in realizing their rights and duty bearers in fulfilling their obligations.

[28] Flavia Bustreo and others, *Women's and Children's Health: Evidence of Impact of Human Rights* (Geneva, WHO, 2013), p. 85, sect. 4.2.

[29] OHCHR and Center for Economic and Social Rights, "Who will be accountable?" (see footnote 16).

57. The 2030 Agenda includes a welcome commitment to "accountability" through "a robust, voluntary, effective, participatory, transparent and integrated follow-up and review framework" (resolution 70/1, para. 72) that respects human rights at the international, regional and national levels. Accountability will be critical to the attainment of the Sustainable Development Goals. Yet what accountability, follow-up and review precisely mean in the context of the Sustainable Development Goals remains unclear.

58. The fields of global health and human rights have, in recent years, developed accountability analysis and institutions, which can inspire accountability for the health-related Sustainable Development Goals and help to shape new arrangements.[30] In 2011, the Commission on Information and Accountability for Women's and Children's Health, established to propose a framework to ensure that commitments made under the Global Strategy for Women's and Children's Health (2010-2015) were met, proposed a tripartite model of accountability, composed of monitoring, review and remedial action.[31] That model, derived from the human rights understanding of accountability, was subsequently taken up by the Secretary-General, including in the Global Strategy for Women's, Children's and Adolescents' Health 2016-2030, which supports the achievement of the Sustainable Development Goals related to women's, children's and adolescents' health.

Monitoring

59. Monitoring means "providing critical and valid information on what is happening, where and to whom (results) and how much is spent, where, on what and on whom (resources)".[31] It is envisaged that follow-up and review will be based on a set of global indicators and data to be complemented by regional and national indicators. The 2030 Agenda makes commitments to "high-quality, accessible, timely, reliable and disaggregated" data.

60. States should ensure that adopted indicators are relevant to human rights in the context of the Sustainable Development Goals and capture the availability, accessibility, acceptability and quality of health care and underlying determinants of health. Participatory governance mechanisms should be in place for disaggregated data collection and analysis, and there must be effective communication of data to decision makers and the population more generally. States should also use innovative methodologies to deal with the challenges of sample sizes.

61. Statistical data are important but not enough for monitoring; they should also be supplemented by qualitative data and information, and analysis by human rights monitoring mechanisms, international organizations and civil society. Monitoring should focus not only on outcomes but also on processes of development and on duty bearers, including States, donors, the private sector, international organizations and civil society organizations. Monitoring, including data, must feed into review processes.

[30] Alicia Ely Yamin and Rebecca Cantor, "Between insurrectional discourse and operational guidance: challenges and dilemmas in implementing human rights-based approaches to health", *Journal of Human Rights Practice*, vol. 6, No. 3 (2014).

[31] Commission on Information and Accountability for Women's and Children's Health, "Keeping promises, measuring results" (WHO, 2011), p. 7.

Review

62. Review means "analysing data to determine whether ... health has improved, and whether pledges, promises and commitments have been kept" by all relevant actors.[31] It will be crucial for review processes to move beyond data analysis to assess whether Sustainable Development Goal commitments, including right-to-health commitments, have been met.

63. Arrangements for monitoring and review at the global, regional and national levels are still being developed. Multi-stakeholder, participatory, transparent and regular reviews will be essential. A wide variety of review mechanisms should play a role, including in political, administrative, judicial and quasi-judicial processes. There is a critical role for independent mechanisms at the national, regional and international levels.[32]

64. Review at the national and subnational levels should take place within existing national structures and processes, including national human rights institutions, policy review processes, comprehensive maternal death audits, patient's rights tribunals, and litigation.[33] For example, national human rights institutions provide accountability for the right-to-health-related Sustainable Development Goals, including by undertaking national assessments and enquiries and by participating in other domestic and international review processes, offering advice to Governments on promoting and protecting rights in national implementation plans and on rights-based implementation, including through support for the development and use of human rights impact assessments.[34]

65. Many of the challenges to and opportunities for achieving the Sustainable Development Goals require international cooperation, for which global or regional accountability mechanisms can be better placed to review progress than national mechanisms. Regional and global review mechanisms should scrutinize whether States have met not only their domestic right-to-health obligations in the context of the Goals but also their obligations of international cooperation, including through development cooperation and trade agreements. Regional and global mechanisms must also find a way to hold the private sector, international organizations and civil society to account.

66. The high-level political forum on sustainable development is the central global review body identified by the 2030 Agenda and is mandated to carry out regular reviews, as well as cross-cutting and thematic reviews. The Special Rapporteur is concerned that the high-level political forum meets only for eight days each year

[32] Paul Hunt, "SDGs and the importance of formal independent review: an opportunity for health to lead the way", *Health and Human Rights Journal*, SDG Series blog, 2 September 2015. Available from www.hhrjournal.org/2015/09/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way.

[33] Rebecca Brown, "Leaving no one behind: human rights and accountability are fundamental to addressing disparities in sexual and reproductive health", *Health and Human Rights Journal*, SDG Series blog, 7 September 2015. Available from www.hhrjournal.org/2015/09/sdg-series-leaving-no-one-behind-human-rights-and-accountability-are-fundamental-to-addressing-disparities-in-sexual-and-reproductive-health.

[34] Steven L. B. Jensen, Allison Corkery and Kate Donald, "Realizing rights through the Sustainable Development Goals: the role of national human rights institutions", Briefing Paper, June 2015. Available from www.humanrights.dk/sites/humanrights.dk/files/media/dokumenter/udgivelser/research/nhri_briefingpaper_may2015.pdf.

and is underresourced. In addition, reporting to the high-level political forum is voluntary.

67. Another key mechanism is the Independent Accountability Panel, appointed earlier in 2016, which will monitor progress towards the Global Strategy for Women's, Children's and Adolescents' Health. The Special Rapporteur welcomes the appointment of the Panel and will follow its work with interest.

68. International human rights mechanisms, including the universal periodic review and independent mechanisms such as the treaty bodies and the special procedures of the Human Rights Council, should consider the role that the Sustainable Development Goals can play in supporting the realization of the right to health and address obstacles to the enjoyment of the right to health that arise in the context of the Goals. The reviews undertaken by those bodies should be considered by the high-level political forum and the Independent Accountability Panel, and vice versa.

69. At the national level, and increasingly at the regional and global levels, judicial and quasi-judicial reviews are playing a role in supporting accountability for the right to health, including on issues at the heart of the Sustainable Development Goals, such as HIV/AIDS and maternal mortality. Litigation can play a special and potentially transformative role where the right to health has been violated.

Remedies and redress

70. Remedies and redress are an essential dimension of human rights accountability but are completely neglected in the 2030 Agenda. Remedies can be understood as "measures to put things right, as far as possible, if they have not gone as promised or planned".[35] Where States are failing to meet their human rights obligations in the context of the Sustainable Development Goals, duty bearers are under an obligation to act.

71. Satisfaction and guarantees of non-repetition are critical to ensuring non-repetition and include, at the national and subnational levels, legislation, judicial remedies and redress, monitoring and enforcement mechanisms, improvements in policy formulation, budgets and planning, and right-to-health training of relevant duty bearers. Review processes should make recommendations for such remedies, and duty bearers should act on them. At the same time, remedies should be available to individuals whose right to health has been violated. Some remedies, such as restitution, rehabilitation and compensation, focus on redressing harm to individual or group rights holders. Judicial remedies are extremely important for redressing violations, and States and other actors should implement relevant recommendations.

[35] The Partnership for Maternal, Newborn and Child Health, "A review of global accountability mechanisms", in *Maternal Mortality, Human Rights and Accountability*, Paul Hunt and Tony Gray, eds. (Abingdon, United Kingdom, Routledge, 2013).

Role of civil society actors

72. Accountability depends not only on robust monitoring and review mechanisms but also on the meaningful engagement and participation of civil society. Human rights and health-related civil society actors should support accountability for the Sustainable Development Goals through monitoring, reporting, advocacy, engagement with national, regional and international review processes, and litigation. States and the international community should create the space for civil society to participate in relevant review processes, and ensure that those processes are transparent and accessible. The involvement of civil society actors is crucial; without them, the 2030 Agenda will be but an empty promise.

73. Providing opportunities for disadvantaged and marginalized groups to fully participate in accountability arrangements will be essential to guaranteeing their human rights in the context of the Sustainable Development Goals.

C. Universal health coverage

74. Universal health coverage is a key dimension of the 2030 Agenda commitment towards achieving healthy lives and well-being for all at all ages. Goal 3 includes an explicit commitment to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (target 3.8) and to "ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" (target 3.7).

75. The intersection of universal health coverage and human rights is a large, complex topic that, from the perspective of the right to health, should include a number of elements, such as the role of the private sector and of international financial institutions. The Special Rapporteur plans to devote space to universal health coverage in his future work and, in the present report, will merely point to a number of features required to establish rights-based universal health coverage.

76. Universal health coverage has been called "a practical expression" of the right to health.[36] It is indeed a core obligation under children's right to health.[37] However, not all paths to universal health coverage are consistent with human rights requirements. Targets 3.7 and 3.8 do not make explicit commitments to confer priority to the poor and marginalized either in the process of expanding coverage or in developing priorities as to which services to provide. Without those clear commitments, there is a risk that universal health coverage efforts will entrench inequality. For example, in countries lacking strong health systems, Governments may pursue strategies that prioritize expansion to groups in privileged positions, such as those working in the formal sector, where infrastructure and opportunistic private or national insurance schemes are readily available. Likewise, countries with centralized and expansive health coverage might soon proclaim achievement of

[36] WHO, "Positioning health in the post-2015 development agenda", WHO Discussion Paper, October 2012.

[37] Committee on the Rights of the Child, general comment No. 15, para. 73.

universal health coverage, even while some of their most vulnerable subgroups are left with health care that is abusive, coercive and/or of poor quality.[38]

77. The prioritization and participation of the world's most vulnerable is vital to both defining and achieving equitable universal health coverage. This is also consistent with core obligations under the right to health to guarantee access to health services without discrimination and to take deliberate, targeted and concrete steps to ensure the effective realization of that guarantee, especially for the most marginalized.[39] Likewise, States have a core obligation to ensure effective and meaningful participation in the development of national health plans, including strategies for universal health coverage, that at the very minimum ensures that the views of the poor and most marginalized are incorporated. If the furthest behind are not prioritized and progressive strategies for expanding coverage for the most marginalized are not immediately established with their active participation, there is a real risk that the target could go unmet by 2030.

Towards a rights-based universal health coverage

78. The Special Rapporteur wishes to emphasize that universal health coverage must be understood as consistent with the right to health. While some components of targets 3.7 and 3.8, namely universal coverage, financial risk protection, access to quality essential health-care services, access to safe, effective, quality and affordable essential medicines and vaccines, and universal access to sexual and reproductive health-care services, can be read as consistent with the right to health,[40] they obscure vital right-to-health standards.

79. Universal health coverage cannot be achieved without meeting the core requirements of availability, accessibility, acceptability and quality under the right to health. Among other things, services must be safely and geographically accessible without discrimination. The right to health requires that essential services include those for populations with specialized needs, such as sexual and reproductive health services adapted to the needs of women, girls, including those with disabilities, and transgender persons. Health services and access to underlying determinants must also be economically accessible. Even where there is widespread access to health services, the right to health demands that they be of sufficient quality, including in good working condition and medically and scientifically appropriate.

80. The right to health also requires that progress towards universal health coverage be monitored to assess who is covered, what services are covered, and the extent of financial protection, with data disaggregated to measure progress across sectors and groups. Focusing on coverage averages (indicator 3.8.1) without disaggregating data can mask exclusion, especially of those most marginalized. Using insurance coverage as a proxy indicator for financial protection (indicator 3.8.2) fails to address the impoverishing impact of health expenditures.[41]

[38] Oxfam International, *Universal Health Coverage: Why Health Insurance Schemes Are Leaving the Poor Behind*, Briefing Paper, No. 176 (Oxford, 2013).

[39] Committee on Economic, Social and Cultural Rights, general comment No. 20.

[40] Committee on Economic, Social and Cultural Rights, general comment No. 14, paras. 43-44, and general comment No. 22, para. 49 (c), (e) and (f).

[41] Audrey R. Chapman, "The problems with the proposed indicators for monitoring universal health coverage in the Sustainable Development Goals", *Health and Human Rights Journal*, blog, 17 March 2016.

81. Moving towards universal health coverage requires long-term progressive realization of the right to health that engages work across many sectors at the local, national, and international levels. The World Health Organization Consultative Group on Equity and Universal Health Coverage has proposed a three-part strategy for countries to progressively realize universal health coverage consistent with equity principles and the right to health. This includes prioritizing the worst off, expanding coverage to everyone and reducing out-of-pocket payments, all while ensuring that disadvantaged groups are not left behind.[42]

82. The right to health recognizes the importance of prioritizing investments in primary and preventive care, which benefits a far larger sector of the population, over expensive specialized health services, often accessible only to a small, privileged fraction of the population. Investing in primary health services prevents illness and promotes mental and physical health, and in turn reduces the need for specialized care.

Financial risk protection

83. In many countries, out-of-pocket payments, such as user fees and co-payments, fees for treatment and indirect fees related to the costs of seeking health care, such as transportation costs, create major barriers to health care.

84. Such costs often have a significant and disproportionate impact on the poor, who pay a considerably larger portion of their total income on health. In turn, they drive many households into poverty or deepen the poverty of those already poor. Such fees could bar those without the means to pay from receiving needed care, as well as discourage people from seeking care in the first place.

85. Private, out-of-pocket payments account for about 50 per cent of total health expenditures in countries where more than 50 per cent of the population is living on less than $2 per day. It is actually the poorest and most in need who suffer from such payments.[43] Universal health coverage consistent with the right to health requires establishing a financing system that is equitable and pays special attention to the poor and others unable to pay for health-care services, such as children and adolescents.

Moving past the biomedical model of health

86. States will not achieve Goal 3 without a robust commitment to addressing social and psychosocial determinants of health, as well as inequalities in income, education, living and working conditions and distribution of resources. Universal health coverage must not be limited to biomedical interventions such as medicines and vaccines but must equally include modern interventions that go beyond the biomedical model, including psychosocial and other interventions that address structural and environmental barriers to health. These interventions should be supported and funded as effective and essential interventions, on par with biomedical interventions, and should not be seen as a luxury available only to rich countries.

[42] WHO, *Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage* (Geneva, 2014).

[43] ILO, *Addressing the global health crisis: universal health protection policies*, Social Protection Policy Papers, No. 13 (Geneva, 2014).

87. The 2030 Agenda affirms that universal health coverage and access to quality health care are necessary to promote mental health and well-being with a specific target to achieve them. This is a welcome advance but fails to address the grossly unmet need for rights-based mental health services.[44] Lack of political will to address mental health as an emerging priority has led to an unacceptable situation with two equally detrimental scenarios: mental health services either are not available for many of those who need them or, when they are in place, too often violate the rights of people receiving care. Unfortunately, in many parts of the world, the entire field of mental health remains hostage to outdated discriminatory attitudes reflected in the lack of political will to invest in community-based social medicine and social psychiatry with a modern public health approach grounded in human rights (A/HRC/29/33, paras. 74-84).

88. Mental health care has been addressed primarily as the management of medical conditions with psychotropic medications and institutionalization, too often without the person's consent. Advancing to the Sustainable Development Goals and universal health coverage is a good opportunity to move to mental health care that is free from outdated policies and practices. Psychosocial and public health interventions that empower people, increase their resilience and address structural factors (such as violence) that contribute to mental ill health are the standard of care, on par with the provision of appropriate and high-quality medications. They must be viewed as part of primary, community-based health care and an integral part of universal health coverage.

Health system strengthening

89. Achieving universal health coverage requires sufficient capacity of well-trained health workers to meet patients' needs. The global health workforce is too small and unequally distributed within and among countries, with poorer countries and communities having the fewest workers. Poor working conditions and low pay contribute to a "skills drain" of health professionals undermining the right to health in communities and countries left behind. This disproportionately affects those with limited finances or access to health care (A/60/348, sect. IV).

90. Strengthening health systems, including by investing in training, recruitment and retention of the health workforce (target 3.c), protecting their rights and improving their wages and working conditions, is essential to progress towards universal health coverage (see A/60/348).

D. Violence as a public health issue in the Sustainable Development Goals

91. Addressing violence cuts across the Sustainable Development Goals and is critical to the realization of the right to health. The Goals envisage "a world free from fear and violence" and include specific commitments to eliminate all forms of violence against all women and girls in the public and private spheres (target 5.2); to eliminate all harmful practices, including child early and forced marriage and genital mutilation (target 5.3); to significantly reduce all forms of violence and related death rates everywhere (target 16.1); and to end all forms of violence against

[44] WHO, *Mental Health Action Plan 2013-2020* (Geneva, 2013).

and torture of children (target 16.2). The Goals also include a commitment to build capacities to prevent violence (target 16.a). In addition, several other Goals address risk factors linked to violence, including ending poverty (Goal 1), ensuring healthy lives and promoting well-being (Goal 3), ensuring quality education (Goal 4), addressing inequalities (Goal 10) and making cities and settlements safe (Goal 11). As recognized in the Goals, reducing and eliminating violence is critical to transforming the world into a peaceful and inclusive global community.

92. Violence is a complex, multi-layered public health phenomenon that affects mortality, mental health, sexual and reproductive health and infectious and non-communicable disease outcomes across the globe.[45] The reduction or elimination of violence within the home, medical and educational settings and broader society is a prerequisite for the realization of the right to health. Violence is one of the most compelling barriers to and determinants of the right to health.

93. There are many forms of violence. Child abuse and neglect, domestic violence between intimate partners and suicide are interpersonal forms of violence. Armed conflicts, State-perpetrated violence, terrorism and organized violent crime are forms of collective violence. Although often viewed and studied as separate phenomena, interpersonal and collective forms of violence share common risk and protective factors and should be addressed as interrelated phenomena.[45] Some of those common risk factors include social, economic and gender inequalities (Goals 1-17), poverty (Goal 1), power asymmetries both in the family and in the community (Goals 1, 5 and 16) and lack of mutual trust and respect. Both forms of violence intensify the risk environment for human rights violations and abuse, especially towards those groups perceived as vulnerable (Goals 3, 5 and 10).

94. To date, the approach to violence reduction has been fragmented, compartmentalizing different forms of violence. Importantly, many forms of violence continue to be tolerated within societies and even supported by States. For example, violence against women and children remains accepted in many societies as a cultural norm. The institutional care of young children, a clear act of violence against children, remains widespread in many countries. Around the world, many groups in vulnerable situations, including women, persons with disabilities, migrants and refugees, and lesbian, gay, bisexual, transgender and intersex persons, experience numerous forms of violence. Each example is also a violation of various human rights protected under international law, including the right to health.

95. A holistic approach to addressing violence is consistent with the aim of collectively implementing the Sustainable Development Goal targets on violence across the agenda. It is also consonant with the indivisible and interrelated nature of human rights. From a human rights and public health perspective, violence must be addressed comprehensively, including obligations to eliminate violence within health-care settings, to address how structural factors, such as laws and policies, institutionalize violence and to eliminate violence against women and children.[46] The right to health also includes an entitlement to safe access to health care and to a

[45] WHO, United Nations Office on Drugs and Crime (UNODC) and UNDP, *Global Status Report on Violence Prevention 2014* (Geneva, WHO, 2014).

[46] Convention on the Rights of the Child, art. 19 (1); Committee on the Rights of the Child, general comment No. 13, para. 7 (a)-(c); Committee on the Elimination of Discrimination against Women, general recommendation No. 19, paras. 1 and 7; Committee on Economic, Social and Cultural Rights, general comment No. 14, paras. 10 and 12 (b); and A/HRC/22/53, para. 84.

safe environment. Importantly, children and adolescents have a right to be free from violence and to healthy development.[47]

96. As the global community is concerned by the increasing prevalence of collective violence, including violent extremism, it is important to note how the relationship between collective violence and interpersonal forms of violence may reinforce and feed one another. For example, violence against children in families can lead to high prevalence of youth violence and may contribute to the phenomenon of violent extremism.[45] Prohibiting boys from expressing emotions from an early age, enforcing a toxic and primitive understanding of masculinity, has been linked to acts of extreme violence by young men and reinforced a tendency to join groups and movements that are involved in collective violence.

97. Rights-compliant violence prevention strategies require a modern public health approach, leaving behind the ineffective and brutal legacy of retributive and punitive means to curb violence. These approaches point to an investment in healthy, non-violent and respectful interpersonal relations. This can include various psychosocial interventions, such as training of parents to raise children in non-violent ways, anti-bullying programmes in schools, and empowerment of persons in vulnerable situations.[48] Through these interventions, the resilience and protective factors in individuals, families and communities are harnessed and promoted.

98. Addressing violence proactively as a public health issue can end the vicious cycle of violence, poverty and helplessness. For this, it is vital that investment in healthy human relationships, emotional and social well-being and social capital be prioritized.

V. Conclusions and recommendations

99. The 2030 Agenda for Sustainable Development and the Sustainable Development Goals reflect an unprecedented political commitment that offers opportunities for the realization of the right to health and other human rights. However, to turn this political commitment into reality, pledges must be firmly grounded in international human rights law and the legally binding obligations to promote and protect human rights, including the right to health.

100. The 2030 Agenda makes a strong call to "ensure that no one is left behind" and "reach the furthest behind first". This reflects the need to seriously address inequities, inequality and discrimination as major threats to global development, which is of crucial importance for the effective realization of the right to health.

101. The Sustainable Development Goals and the right-to-health framework have much to offer each other. Importantly, where the health-related Goals show weakness and lack of clarity with regard to implementation, the right to health will be a powerful tool to ensure effective and equitable achievement of the Goals. Embedding equity, non-discrimination and equality, participation

[47] Convention on the Rights of the Child, arts. 6, 19 (1) and 24; and Committee on the Rights of the Child, general comment No. 13, para. 7 (a)-(c).

[48] UNODC, "Compilation of evidence-based family skills training programmes". Available from www.unodc.org/documents/prevention/family-compilation.pdf.

and accountability in the implementation of the 2030 Agenda firmly harnesses the normative value of human rights, placing them at the heart of the Goals.

102. The 2030 Agenda provides momentum to pave the way, both in developing and developed countries, for sustainable investments in modern public health policies and break the vicious cycle of poverty, inequities, social exclusion, discrimination and violence. States and other actors implementing the Sustainable Development Goals must not be tempted to target the "low-hanging fruit" at the expense of the most marginalized and vulnerable.

103. As a matter of priority, the Special Rapporteur recommends that:

(a) Member States ensure full compliance with universal human rights law and principles and refrain from selective approaches to upholding the right to health and related human rights when developing strategies towards the implementation of the Sustainable Development Goals;

(b) Member States ensure attainment of the Sustainable Development Goals through the review of existing national and local legal and policy frameworks to assess their compatibility with the right to health and ensure that national laws, policies and programmes include targeted actions to support enabling legal and policy environments, with attention to the rule of law, health governance, law enforcement and access to justice;

(c) Member States act in conformity with their obligations to respect, protect and fulfil the right to health in all their efforts to achieve the Sustainable Development Goals, and not only Goal 3;

Leaving no one behind

(d) Member States explicitly prohibit discrimination on any grounds that has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health and, in this connection, review existing laws, policies and practices, with the aim of removing those that are discriminatory in nature and practice and obstruct implementation of the key principles of the Sustainable Development Goals;

(e) Member States identify disparities and prioritize the most vulnerable through collection and disaggregation of health-related data, using both qualitative and quantitative methods, to monitor progress and support review and accountability in the implementation of the Sustainable Development Goals;

(f) Member States ensure, through concrete legal and policy measures, that rights holders, in particular those in the most vulnerable situations, are empowered to participate in the design, implementation and monitoring of laws, policies and practices relevant to implementing the Sustainable Development Goals and realizing the right to health;

(g) Member States remove all measures that restrict the space for civil society, and ensure safe and enabling environments for civil society actors so as to guarantee a meaningful and respectful partnership with the State;

Universal health coverage

(h) Member States use the right-to-health framework to develop national plans to strengthen health systems and set priorities by addressing inequalities, which is the main goal of universal health coverage;

(i) Member States invest in effective, transparent and accountable health-care systems, with a focus on primary health care and health promotion, and address imbalances and power asymmetries within and beyond health-care systems in all decisions aimed at reaching universal health coverage;

(j) Member States fulfil immediate or core obligations under the right to health to guarantee access to health services without discrimination, and take deliberate, targeted and concrete steps to ensure the effective realization of this right, especially for the most marginalized;

(k) Member States ensure that the focus on addressing financial exclusion does not neglect the equally important issue of discrimination on other grounds, such as race, colour, sex, religion, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and gender identity, age and civil, political, social or other status;

(l) Member States consider expanding the focus of investment in physical health and reduction of mortality, traditionally based on the classical determinants of health such as poverty, education, housing and water and sanitation, to address other determinants, including the quality of physical and psychosocial environments;

(m) Member States ensure that the focus on access to essential medicines and other life-saving interventions does not neglect equally important non-biomedical interventions, including psychosocial interventions, that promote mental and physical health and well-being, reduce violence and contribute to the realization of the right to health and the Sustainable Development Goals;

(n) Member States ensure that the focus on providing accessible and free health care for all and closing the treatment gap does not undermine the need to protect and monitor human rights in patient care, so that health-care services are free from discrimination and violence;

Violence

(o) Member States ensure political commitment at all levels to reach common understanding and agreement that all forms of violence, and not only the most severe ones, are not accepted and should not be tolerated, without any exceptions;

(p) Member States ensure that health-related and other policies addressing violence do so by tackling all forms of violence, and avoid exceptions or selective approaches that condone or tolerate certain forms of violence;

(q) Member States guarantee substantial investments in healthy human relationships, emotional and social well-being and social capital, starting from

interventions that address infant-parent interactions in early childhood and moving through the entire life cycle;

(r) Member States prioritize human and financial resources to address all forms of violence as public health issues, especially in childhood and family policies and services, and ensure that these interventions are considered a priority in health-related policies and integrated as part of universal health coverage;

(s) Member States comply with obligations under the right-to-health framework to address violence, using modern public health interventions, especially regarding children and adolescents, and to that end, adopt legal and policy measures to eliminate all forms of violence against children;

Accountability

(t) Member States ensure that the high-level political forum on sustainable development meets as often as needed, is well resourced financially and with relevant expertise, and that States report on a regular basis after conducting monitoring and participatory reviews at the national level; the high-level political forum should consider reviews undertaken by international human rights mechanisms, such as the universal periodic review, treaty bodies and special procedures of the Human Rights Council;

(u) United Nations human rights procedures, such as the universal periodic review, treaty bodies and special procedures, hold States to account for the right to health in the context of their Sustainable Development Goal-related efforts;

(v) At the national level, Member States ensure the operation of a wide range of accountability processes, including judicial, quasi-judicial, political and administrative mechanisms, and ensure that they are transparent, accessible, participatory and effective;

(w) Member States ensure the collection of high-quality and timely data for the Sustainable Development Goals that are disaggregated in line with the "stratifiers" identified in the 2030 Agenda, and on further grounds as appropriate in the health context of different countries, in order to make visible the reality and needs of marginalized populations;

(x) Member States ensure that data are collected and analysed in a transparent manner and made available and accessible to all relevant stakeholders;

(y) National human rights institutions engage in supporting accountability for the Sustainable Development Goals, for example by undertaking national assessments or enquiries and by providing advice to policymakers.